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THE SOCIAL AND REHABILITATION

Record

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THE SOCIAL AND REHABILITATION
Record

Volume 1, Number 4 April 1974

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San Antonio improves health care for poor

A program to improve health care for the indigent in Bexar County, Texas, is reducing emergency room visits and providing treatment closer to home for the chronically ill, according to Dr. Harold Viaille of SRS in Dallas.

The project involves the remodeling and expansion of the intake clinic for the poor at Robert B. Green Hospital in San Antonio and a followup program for patients with certain chronic diseases.

The formerly crowded intake clinic was completely renovated. New equipment was added. Also added was a pediatric unit, a laboratory, a poison control center, an acute trauma management center, a seven-bed observation facility, more examination rooms, a counseling area, a pharmacy waiting area, and new patient waiting rooms.

Dr. Viaille said the expansion improves patient flow and enables medical personnel to provide more immediate care for the poor in dignified, pleasant surroundings.

Administrative personnel were trained as counselors, primarily to identify patients who might be eligible for public assistance benefits, rehabilitation services, and the new followup program for long-term care of the chronically ill.

As a result, each new adult patient now receives on-the-spot counseling and is referred to additional sources of help. This service was not available until SRS provided its research and demonstration funds for the program.

Followup care for chronically ill patients—the second step in improving medical care for the poor—includes referrals from the emergency room and inpatient service center at Bexar County Hospital and community clinics, as well as from the intake clinic at Robert B. Green Hospital. Initially, the program was designed to concentrate on only one disease, diabetes mellitus, as a test.

A patient is selected for the followup program when his case is determined to be stabilized, he lives near a community clinic, and he desires followup treatment at a nearby clinic rather than a hospital.

The followup program is designed to use trained paramedical people in direct care of patients as much as possible, allowing physicians to supervise the treatment of more cases.

After 3 years, the community clinics now treat an average of 800 followup patients each month. With the success of the program, it is being expanded to include care of chronic hypertensives and other chronic diseases.

NYC police receptive to deafness needs

The New York University's Research and Training Center's advocacy efforts have assisted the New York City Police Department to become more alert to and understanding of the problems of deaf people. A Police Academy Training Bulletin, *The Deaf and the Police,* resulted from meetings between center staff and police officials to discuss police procedures with deaf people.

A second outcome of these meetings was the installation of a teletypewriter at New York City Headquarters to enable deaf people to secure police assistance in emergencies.

The center also has provided data and assistance to the Inner City Insurance Agency which has helped the company to provide a special insurance program for deaf drivers.

DVR director lauds advisors' usefulness

In his "Gusts from Gus" column in the Minnesota Division of Vocational Rehabilitation *Bulletin Board,* Director August Gehrke defends the usefulness of advisory committee members as extending beyond their "committee tour of duty." He illustrates his point by telling about a past committee member in these words:

"Some of you may remember Helen Gill, of Gill Brothers Clothiers in Bemidji, who served on our advisory committee a few years back. Although Helen no longer has a formal responsibility in the rehabilitation field, and although her business duties are extensive and demanding, Helen has never forgotten the handicapped and continues to devote substantial time and effort on their behalf.

"Every now and then I learn of another service she has performed—how she works with our office in Bemidji in making referrals—how she hired someone who had a paraplegic wife, and the fun she had trying to find an apartment that would accommodate a wheelchair—the extensive contacts she makes with other persons in the clothing business to stress that store planning should be undertaken with the needs of handicapped people in mind—how she suggested to the Detroit Lakes Technical Institute that they should teach students of store design to remember the handicapped and their accommodation needs.

"I recently received a letter from Helen, in which she said: 'I have such a soft spot in my heart for DVR and appreciate all you let me learn the 3½ years I was on your advisory committee . . . Please remember me to friends in your office.'

"Well, I certainly will do that, but the appreciation and thanks should

go the other way—to Miss Helen Gill of Bemidji. God willing that we might have many others like her, and the plight of the handicapped would be much more equitable."

Community cooperates in training workers

During the first 16 months of operation, the Southwest Virginia Cooperative-Vocational Rehabilitation Project has rehabilitated 65 public assistance recipients to jobs in Wythe and Smyth counties.

The project is one of seven in Virginia and is a cooperative effort among the State Division of Vocational Rehabilitation, the Department of Welfare and Institutions, the Smyth County Department of Public Welfare, and the Wythe County Department of Social Services.

Mrs. Alice Barker, DVR unit supervisor, says it is a total community effort. Several schools are being used for training the welfare recipients—vocational schools in both counties, a technical school, and a community college. Businesses are providing on-the-job training. Mrs. Barker says that employers in both counties have been receptive toward hiring the clients. A followup is made to help clients make a satisfactory work adjustment.

National Arts Council urges access program for the handicapped

The National Endowment for the Arts, an independent agency of the Federal Government, has adopted a resolution that encourages cultural facilities to open their doors to all people, including the physically disabled. The resolution emphasizes that "the arts are a right, not a privilege."

In commenting on the resolution, the chairman, Miss Nancy Hanks, said: "The Council has acted in response to the expressed concern of the Congress, arts and civic leaders, and public officials, as well as private citizens who recognize that an important segment of our society—those with physical handicaps—are often barred from cultural performances and exhibits simply because the facilities prevent their participation."

Two actions have been approved as a first step in attaining its goals. The museum program guidelines for FY 1975 have been revised to include provisions for matching grants to survey necessary changes to make museums accessible. Its second action came with a grant to the University of Illinois to set up workshops for architects and engineers to study accessibility problems. Under the grant terms, actual projects will be designed and will serve as models.

Deafness center eases communication

The Deafness Research and Training Center of the New York University School of Education has successfully sponsored periodic Orientation to Deafness seminars for professionals whose work establishes occasional contacts with deaf persons. The 2-day sessions are held throughout the year in SRS Region II areas—New York, New Jersey, Virgin Islands, and Puerto Rico—at times providing sign and speech translation in both Spanish and English.

Each seminar approaches social workers, doctors, policemen, and certain VR counselors with a crash course introducing them to the deaf community. Discussions and consultations provided by Deafness Center and Rehabilitation department staff orients the professionals to easier communication and understanding with their deaf clients.

Child abuse legislation studied in Region VI

Under the direction of Dr. Clara Johnson, the Social Welfare Research Institute, University of Georgia, has completed a Region VI study of child abuse legislation and programs. A research monograph, *Child Abuse: State Legislation and Programs in the Southeast,* which includes recommendations for altering and improving State child abuse reporting systems, has been released. It is available from the institute.

Dr. Johnson is conducting further analysis of this problem in a random regional sample of approximately 1,000 abuse cases. The study of case characteristics (cause, time of day, and nature of incidents) is expected to produce recommendations for improving community child abuse service delivery systems.

Out of the Institution

A program of community living for the mentally retarded now serves 662 persons in Pennsylvania, and the State Department of Welfare plans on expanding it to help about 7,000 persons within 5 years. The program, aimed at minimizing the institutionalization of retarded persons, makes use of group homes and apartments in communities where the retarded are helped toward independent living. Each home serves 8 to 12 persons who previously lived in institutions.

HARLAN AREA VOCATIONAL SCH. D.

Putting WIN Itself To Work

LYNN HAYES and LYNN PEARSON

Vanetta Vaughn lives and works in Harlan, Kentucky. Every morning at 5:30 she drives 10 miles to the Black Diamond restaurant and turns on the grills for breakfast. Before she closes at 10 p.m., she and her four employees will have cooked three meals, served over 100 customers, written the next day's menu, paid bills, balanced books, and mopped floors.

Two years ago, she didn't have all that responsibility. She was on welfare. Through the Work Incentive Program, she escaped the rut of poverty, boredom, frustration, and insecurity.

Administered by the Kentucky Department for Human Resources, the program helps able-bodied welfare recipients find gainful employment.

Divorced from her husband in 1969, jobless and confronting the possibility of needing immediate medical care for her oldest daughter, Ms. Vaughn was like many mothers caught in crisis. With no other recourse, she sought financial aid from the local public assistance office.

"I don't know what I would have done if public assistance hadn't picked up my medical bills," she said.

Soon a service worker from the Harlan County public assistance office referred her to the WIN program. With the help of the Harlan WIN team, she obtained her high school diploma. After an unsuccessful attempt at nurses' training, she found a job as a waitress at the Townside Restaurant and later began working at the Black Diamond.

Ms. Vaughn was soon offered the job as restaurant manager. Presently, she is doing $3,500 worth of business monthly and after employees' salaries and bills are paid, she takes home about $600-700.

Many of Harlan's working mothers who have taken part in WIN don't have opportunities like Vanetta. For some, take home pay is as low as $200 a month, and they are still receiving supplemental welfare checks.

In December 1971, Senator Herman E. Talmadge of Georgia proposed an amendment to the Social Security Act of 1967. The amendment, put into effect in July 1972, changed the old Work Incentive Program from a voluntary self-improvement training program for people receiving AFDC to a mandatory program requiring all able-bodied, federally qualified welfare recipients to register for work or training for employment.

Under the old law, the program emphasized job training and schooling for welfare recipients, primarily welfare mothers. The State paid 20 percent of total program costs for WIN manpower activities and 25 percent of supportive services and child care costs.

Under the new law, the emphasis shifted to a job placement program, and the federal share was raised to 90 percent.

Every AFDC welfare recipient must now register for the WIN program before qualifying for welfare payments, unless he is a child under 16 or a full-time student; ill, incapacitated or elderly; required to be at home to care for a sick or incapacitated family member; caring for a child under 6; or caring for a child in a home where the father or other adult male is already registered in the program.

After persons are registered and appraised to determine their employment potential, the Special Administrative Unit (SAU) arranges for the provision of employment-related, supportive services, such as child care, to enable them to accept employment or job training. The manpower agency worker in the local employment office provides counseling, training, vocational guidance, and job development services.

Since the program went into effect in July 1972, 2,654 welfare recipients in Kentucky have been placed in jobs and 17,212 have been registered for work. In Harlan, 1,019 families

(total of 3,631 persons) receive public assistance. The Harlan WIN team has registered 618 of them for work and placed 130 in jobs. Most of the activity has taken place since January 1973. As of then, only 281 were registered and only 30 had been placed in employment.

The Staff

The WIN program in Harlan has one strong point in its favor—high-caliber, fast-moving staff members who work together as a team.

■ Britt Lewis, 28, joined WIN as an interviewer aide and is now a job developer who helps place participants in jobs or training. He recently earned his degree in vocational guidance and counseling from the University of Louisville.

Lewis enjoys working with employers and exploring job leads, and he has a knack for uncovering new employment possibilities. Usually when he is working on an on-the-job training contract with an employer, he has someone in mind and recommends that person.

Lewis claims he and Bill Ellis, WIN unit supervisor, have much freedom and flexibility with their job, but he spoke of bad points, too: low-paying salaries and massive paperwork.

The WIN team's first contact with the client is through the income maintenance worker in the local welfare office. If the recipient is a mandatory registrant, the worker forwards the case to the SAU worker in the welfare office.

■ Gary Vanover, SAU worker, is new to the WIN program and sometimes sees his job as simply a "statistician and child care provider."

Commenting on the paperwork, he said: "From the time a welfare mother is enrolled until she is terminated, we may have as many as 27 federal, State, and county forms on her."

At times, Vanover has more responsibility than the average service worker. He visits the recipient's home, prepares her for the appraisal interview, takes part in the interview, sets up child care services, and provides any additional services.

■ Florence Dean, senior service worker in the Harlan County public assistance office and Vanover's immediate supervisor, says the high staff turnover among SAU workers has been a headache.

Ms. Dean said that a big problem is the lack of a consolidated manual of operation for public assistance and employment service WIN workers. She says supervision is split three ways, all of it coming from Frankfort. Some of it comes by telephone and no one puts the instructions in writing. [Federal officials say that a consolidated handbook can be developed and that work in this area is now in progress. Also of help in this area is the new colocation program which will bring closer federal, regional, State, and county workers.]

■ Rita Dickson, principal employment counselor and supervisor of employment service activities in Harlan and Middlesboro employment offices, keeps in close touch with the WIN team.

The newest member of the Harlan WIN team is Dorothy Gray. She administers the General Aptitude Test Battery. Recently she began making home visits.

"We needed a woman counselor," said supervisor Ellis. "Sometimes the participants have problems that they would rather not talk to me about."

The Client

Yolanda Nolan, executive secretary for the Community Action Agency in Harlan, is a working mother. She is divorced, has two high school aged sons, and receives no child support. She has rheumatoid arthritis. She says her doctor told her not to walk unless it's absolutely necessary.

Until a year ago, Ms. Nolan was on welfare. She had difficulty finding work, but she believed she could do any job if given the chance.

A chance, an opportunity—that's what the WIN program has given to at least 100 welfare mothers in Harlan since January 1972.

Helen Ledford, a former WIN participant, worked as a case aide for the Kentucky Infant and Preschool Project in Harlan and now is with the Kentucky Department for Human Resources.

With five children, she was on welfare for 10 years before she became a WIN participant in 1969. During that period, she sometimes made as little as $3 a day cooking at the local club or $1 a day cleaning house.

"The WIN program was a great thing for me to get into," she said. "I got good training; my baby-sitting and transportation was paid for. I couldn't have done it any other way."

Today, two of Ms. Ledford's children are in college, one is a nurse, and two are still in high school.

Frances Clutts, who has a young son and has been on welfare since 1965, found out about WIN in 1969. At that time, the program was not designed to cover college expenses, but that didn't stop her. Encouraged by WIN unit supervisor Bill Ellis, Ms. Clutts secured both a federal and a hospital loan to pay for 2 years' nurses training. WIN was able to pay the third year's training expenses. While the program did not pay the first 2 years' tuition, it provided for child care, transportation, and medical services for her.

She is now a registered nurse at the Harlan Appalachian Hospital and makes about $8,000 per year.

Not all WIN mothers have this kind of financial success. Most are highly motivated but may not be as confident of their skills. They live from one day to the next, hoping to feed themselves and their children, pay their bills, and keep their heads above water.

A woman wants off welfare, and she registers for work. If she is not ready for a job, she can get up to 1 year's vocational training, 15 weeks on-the-job training through WIN, or be directly placed on a job. She then goes to work. For 3 months, she earns $250-300 a month and gets transportation, child care, medical care, and food stamps.

After 3 months, these benefits may be removed. She is terminated from the WIN program, and she may or may not qualify for a supplemental public assistance grant. It will depend on her take-home pay after all work-related expenses have been deducted from her salary.

"You figure a mother pays a minimum of $15 a week for baby sitting, $18 for transportation, $5 for lunches, and earns $1.60 an hour," said Ellis. "She may clear $10 a week. How can anyone live on that?"

The working mother sometimes must go back to the public assistance office to obtain supplemental financial aid.

Training

How many women auto mechanics are there in the country? How about air conditioning and refrigeration repairwomen, electricians, welders?

Under WIN, welfare mothers could receive training in any of the traditionally masculine vocations. All are offered at the Harlan Area Vocational School and require only minimum travel. However, many welfare mothers do not want to leave their homes.

Jobs are not plentiful in the Harlan area, but WIN job development has been successful in opening jobs in business, food services, child care, clothing, and practical nursing.

Many of the teachers have been favorably impressed with the work of WIN students. The class prepares lunch for the teachers three times a week.

"I gear my course to the job the women will hopefully get when they leave," said Cleta Boggs, food services instructor. "It's more than training. When they leave here, they can handle any situation from writing out food tickets to cooking a full meal."

The atmosphere in the food lab is informal. Most of the women attend class 6 hours a day, 5 days a week. During the first semester, Ms. Boggs teaches the basics of good nutrition, food preparation, safety, and sanitation. In the second semester, enrollees learn such occupations as cafeteria service waitress, hostess, lunch counter waitress, salad girl, kitchen helper, and dietary aide.

Placing her students is what Ms. Boggs enjoys the most. Last year she had job possibilities for all her graduating students, in this depressed area.

Within the current training limitations, the most lucrative field for trainees in Harlan is practical nursing. The job market is good, and the salary levels—$400 to $600 a month—are the best that 1 year's training can offer.

According to Mildred Winkler, administrator of the Pineville School of Practical Nursing, the market for licensed practical nurses will continue to be good in eastern Kentucky. There are currently nine WIN participants enrolled in the school, and half of them have received their high school diplomas.

"Many of our students have only a seventh or eighth grade education," Ms. Winkler said. "We really need a prevocational unit geared for nursing students to teach them skills and orient them to health terms."

Aiming at the business and clerical profession, sometimes as many as 14 WIN participants are enrolled in the Middlesboro School of Business,

which is about 40 miles away.

A major limitation is the 1-year ceiling on training. Short-term training means quick job placement, but it may mean a quick return to the welfare rolls.

Betty Ingram, field office supervisor in the Harlan County public assistance office, claims the workers "can hardly get these mothers into the program and have them trained for any type of gainful employment in that length of time." Most vocational courses take at least 2 years. LPN training is an exception, but it is difficult finding qualified applicants.

The Employer

Dalton Smart is an employer, and some say he is among the best in the county. He strives to remove poverty from Appalachia and raise the standard of living. He pays his employees a minimum hourly wage of $2.25 and offers good benefits—2 weeks paid vacation, nine paid holidays, double time for work on holidays, and group-rate life insurance.

Mr. Smart is assistant administrator at the Harlan Appalachian Regional Hospital. Like his predecessors, he is helping to fulfill the dream of John L. Lewis—providing quality medical care to eastern Kentucky.

Many of the registered nurses, licensed practical nurses, and nurses' aides at the hospital are former WIN participants. Smart supports the WIN concept and claims the people of Appalachia needed this type of program to help obtain training and build the incentive to get and hold a job.

Observing that former welfare recipients seem to have a poorer attendance record than other employees, he says much of the problem probably is due to difficulties in transportation and obtaining baby sitters.

Eastover Coal Company employs about 590 workers from Harlan and Bell Counties. Last year they hired Wanda Davis, a WIN participant, and trained her as a keypunch operator. Ms. Davis has a year's training in clerical work and started at a salary of $280 a month. Four months later, she received a sizeable raise, which was unusual for women workers at Eastover. She runs the keyboard machine and uses a computer to do the payroll, costs reports, and inventory.

The Harlan and Middlesboro local offices have been another good place of employment. Joyce Murray, 23, began working for the Middlesboro employment office in March 1972. Formerly she was a clerk for the county judge. Her position was funded through the Emergency Employment Act. She transferred to the employment office, where she does everything from filing to interviewing clients and filling out job orders.

The Community Action Commission is a big WIN employer in Harlan. Between 20 and 30 participants have worked in its varied programs. Anna Lee Gibson, the Commission's executive director, says the WIN program has been helpful to her, especially through the 13-week work experience component where WIN has paid the participant $30 a month incentive pay plus training expenses. Ms. Gibson notes that many employers are not interested in hiring low-income people unless they are sufficiently trained.

Aside from the Talmadge amendments which established new priorities for WIN, a second piece of legislation influenced program activities—the Revenue Act of 1971. It gives employers who hire welfare recipients under WIN a chance to claim dollar-for-dollar credit up to 20 percent on income or salaries paid to the participant during the first 12 months.

The WIN employee must be a full-time employee and must stay on the job at least 1 year beyond the first 12 months for the employer to receive the credit, unless he voluntarily leaves the job, becomes disabled, or is discharged for misconduct.

The tax credit has benefitted 130 Kentucky businessmen since it went into effect.

Lewis anticipates on-the-job training to be more of a selling point than tax credit in persuading Harlan employers to hire WIN participants.

And so it is in Harlan, with a smooth meshing of the WIN team, the participant, the training, and the employers, many AFDC women are assuming responsible tasks in the community. They are leaving the welfare rolls or lessening their dependence on it. Most of all they are contributing to the economics of this Appalachian area.

Ms. Hayes and Ms. Pearson were former public information officers with the Department of Economic Security (now the Kentucky Department for Human Resources), Frankfort, Ky.

The Administrative File

Each month the SOCIAL AND REHABILITATION RECORD will carry a listing of SRS administrative issuances for previous months. Over the course of a year, the RECORD will have presented a complete bibliography of administrative issuances for the year.

The following are the administrative issuances for the month of January 1974. (Abbreviations key: **PR**-Program Regulations; **PRG**-Program Regulations Guides; **PI**-Program Instructions; **IM**-Information Memoranda; **FSI**-Field Staff Information and Instruction Series; **AO**-Administrator's Office; **MSA**-Medical Services Administration; **APA**-Assistance Payments Administration; **CSA**-Community Services Administration; **RSA**-Rehabilitation Services Administration; **NCSS**-National Center for Social Statistics.)

When ordering reports, please specify the appropriate room number for the particular report: For NCSS reports, write NCSS Reports Clerk, Room 2620; for PR reports, write PR Reports Clerk, Room G-115B; for AO reports, write AO Reports Clerk, Room G-115B; and for all other reports, write Reports Clerk, Room 5219.

Send all requests with the appropriate room number to Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 330 C Street S.W., Washington, D.C. 20201.

APA-PI-74-9: Interpretation of 206.10(A)(8) (1/29/74)

AO-IM-74-26: Review of Utilization of Care and Services (1/9/74)

AO-IM-74-27: Implementation Secs. 207 & 247 Skilled Nursing SSA: (1/31/74)

AO-IM-74-28: Correction to Compilation (1/31/74)

AO-PR-10-11 (C-16); 40-12 (C-3); 40-22; 40-11(C-7): Skilled Nursing Facility Regulations (1/17/74)

AO-PR-30-4(C-4): Social Services—Postponement of Effective Date (1/9/74)

AO-PR-40-10(C-3);10-11(C-17); 40-11; 40-23: Intermediate Care Facilities Services (1/17/74)

AO-PR-10-15: Sterilization (1/28/74)

AO-PR-10-14(C-1): Food Stamps Postponement (1/30/74)

RSA-PI-74-17: Distribution of FY 1974 Allotments and Estimated Grants for the Basic Support Program Under Section 110 of the Rehabilitation Act of 1973 (1/17/74)

RSA-PI-74-18: Title XVI Expenditure Report for Make-Ready Costs (1/23/74)

RSA-PI-74-19: Human Interest Story of Successful Rehabilitations of Social Security Disability Insurance Beneficiaries (1/24/74)

RSA-PI-74-20: State Plan Amendment—Vocational Rehabilitation Services for Blind and Disabled Supplemental Security Income Recipients (1/31/74)

RSA-IM-74-36: Distribution of the "Quarterly Status Report of Social Security Disability Insurance Beneficiaries"—Quarter Ending September 30, 1973 (1/10/74)

RSA-IM-74-37: Two Documents on Rehabilitation of Disabled Public Assistance Recipients: Tenth Institute on Rehabilitation Services (1/18/74)

RSA-IM-74-38: Preliminary Report on Characteristics of Rehabilitated Clients—Fiscal Year 1973 (1/22/74)

RSA-IM-74-39: Number of Rehabilitations: July 1 to November 30, Fiscal Years 1973 and 1974 (1/24/74)

RSA-IM-74-40: Training Services for State Vocational Rehabilitation Agency Clients in Institutions of Higher Education (1/29/74)

RSA-IM-74-41: Vending Stand Report for FY 1973 (1/29/74)

RSA-IM-74-42: Percentage Rates to be used by the State Agencies in Calculating "Estimated Allowances in Lieu of Expenditures" for Fiscal Year 1974 (1/30/74)

CSA-PI-74-6: Federal Apportionment, Minimum State and Local Matching and Federal Share Precent for CWS Under Title IV, Part B of the Social Security Act, as amended for 74 (1/16/74)

NCSS-PI-16: Interim State Agency Report on Staff Development Expenditures, Form SRS-NCSS-114-T (1/25/74)

NCSS-PI-17: Amplification of Instruction for the Classification of Recipients on the Monthly Statistical Report on Medical Care Form SRS-NCSS-120 (1/25/74)

NCSS-IM-74-5: 1973 AFDC Study-Follow-up Survey of Cases Discontinued During 1973 (1/28/74)

MSA-IM-74-9: Medicare Inpatient Hospital Deductible and Coinsurance for 1974 (1/17/74)

MSA-IM-74-10: Public Law 92-233, 1973—Social Security Act Amendments (1/21/74)

MSA-PI-74-4: Preprinted State Plan for Medical Assistance Programs under Title XIX (Reference: MSA-PI-74-2, MSA-PI-72-3) (1/28/74)

MSA-PIM-74-7: Extension of Certain SNF Provider Agreements in 1974 Pending New Agreements under NEW SNF Regulations (1/4/74)

MSA-PIM-74-8: Clarification of Policy re: Responsibilities for Civil Rights Compliance Surveys in Medicaid and Medicare Facilities (1/7/74)

MSA-PIM-74-9: Interpretation of P.L. 92-603, Section 249D, *Limitation on Institutional Care* (45 CFR 233.145) (1/11/74)

MSA-FSI-74-40: Exemplary State HMO Guidelines, Model Contracts, and Reporting Requirements (1/3/74)

MSA-FSI-74-41: Limitation of Federal Participation for Capital Expenditures—Section 1122 of the Social Security Act (1/4/74)

MSA-FSI-74-42: Summary of Status of Implementation of EPSDT for Quarter Ending September 30, 1973 (1/10/74)

MSA-FSI-74-43: Final Regulations (Pending Clearance)—Medicaid Eligibility Under SSI (1/15/74)

MSA-FSI-74-44: Referral of Medicaid Cases to the U.S. Attorney's Office (1/22/74)

MSA-FSI-74-45: Field Staff Information and Instruction Series: FY-74—Provider Fraud and Abuse (1/28/74)

MSA-FSI-74-46: Economic Stabilization Program (1/31/74)

How Rehab Personnel Keep Up with Change

LAURA A. EDWARDS

Staying up to date in the field of rehabilitation in this age of change is no longer an easy task, for the field has fallen prey to the information explosion. While 250 research and demonstration project final reports were published between the years of 1955-1960, by 1973 over 2,200 were available as technical information. Where yesterday the emphasis was on physical disabilities, the mentally retarded, and the mentally ill, today the rehabilitation practitioner must also be able to deal with concepts, such as the disadvantaged, drug abuser, the paraprofessional. Tomorrow—who knows?

The rehabilitation professional himself has changed. In the early years of the rehabilitation agency, the professionals consisted of counselors, supervisors, and administrators (who, for the most part, had worked their way up through the ranks); now it is not unlikely to have psychologists, social workers, teachers, physicians, physical therapists, occupational therapists, and others as part of the agency team.

Because cooperative programing is very much a part of the picture today, the rehabilitation agency is affected by the changes in other agencies or departments. As Norman L. Meyers put it, "As medical technology crosses new frontiers, vocational rehabilitation is not far behind." (Norman L. Meyers in "Adapting to VR's Future Shock," *Journal of Rehabilitation,* Vol. 38.) In view of the new discoveries, better techniques, more efficient methods, and different approaches being espoused, how can

the rehabilitation professional even hope to stay abreast?

In his effort to stay on top of his area of expertise, the typical rehabilitation worker of today attends conferences, training programs, joins one or two associations, and reads available literature. In comparison with those in many States, the rehabilitation professional in Virginia has an added advantage. He has ready access to a large quantity of rehabilitation literature, as well as professional assistance in determining the dimensions of his informational needs.

The research library, located in the State Office of the Virginia Department of Vocational Rehabilitation, offers research materials for the informational needs of almost everyone in the helping professions. Here the administrator may find help in policy formulations, statistical studies, decisionmaking, personnel staffing, program justification, program monitoring, and evaluation.

Program planners can find materials which offer new perspectives on present programing, as well as suggestions for the development of new programs. They will be particularly interested in feasibility studies, program and project justifications, demographic data, cost-effectiveness, and specific disability groups, all of which are embodied in the onhand literature.

For the practitioner, much information is available for solving problems in the service delivery process. Among requests made have been the following: What type of jobs can the mentally retarded handle? What are the special needs of the disadvantaged? How does one tell the employer that the epileptic can handle the job adequately? What is the role of a new evaluator? How can group counseling be utilized with a large caseload?

The librarian prepares a listing of new acquisitions each month in a bulletin entitled *New Books,* and describes briefly several research reports in another monthly publication called *The Linker.* If an item sounds appealing to the reader, he merely circles the number of the item desired on the perforated section at the bottom of either publication and returns it to the library. The *Linker Links,* which is mailed out as part of *The Linker,* is designed to be kept in lieu of the original report. It generally highlights in one or two pages the significant findings of a selected research report. Printing and mailing of these publications are handled by rehabilitation workshops.

These publications generate an average of 60 requests a month.

Displays and exhibits at conferences, workshops, and training sessions also attract potential users, along with providing on-the-spot information at the time of need. Generally the display consists of research reports that are geared to the topic of the workshop; a four-paneled, foldup bulletin board that describes services and how to use them; a revolving centerpiece (to attract initial attention); and an electrical device called the *Photo Linker.*

The *Photo Linker* is, actually, an electrically wired question box which stands 3 feet tall and on which is found 10 questions with multiple-choice answers. After reading a particular question, the reader pushes button A, B, or C to indicate his answer. If the right answer is given, a light comes on.

Several research briefings have been conducted by the librarian for State office staff. Using various audiovisual aids, she describes the significant points in a chosen research report in a 20- to 30-minute oral presentation. Afterwards staff members discuss the implications for present programing.

Knowledge of the contents and services of the library is acquired also through visits to the library and from the librarian. All new staff members tour the library during their 1st day of orientation. They are briefed on the policies and procedures for checking out materials. When requested, the librarian visits local area staff meetings to explain what is new and to elaborate on the rehabilitation information system.

Whenever the librarian becomes aware of a new project or program in the agency, a package of appropriate abstracts is prepared for the project director. This gives him an overall view of other obtained results.

The final interest stimulating technique is not readily perceived as such. The librarian attaches an evaluation slip on the front cover of each check out item. This enables the reader to express both his negative and positive feelings regarding the value of the material.

Resources include the materials in the SRS research information system.

The bulk of the 3,000 soft-bound, research-oriented materials are final reports of research and demonstration (R&D) projects sponsored by SRS. Although many of the holdings were obtained by writing directly to project directors, this material is now sold by the National Technical Information Service, U.S. Department of Commerce, Springfield, Va. 22151, in both hard copy (actually soft-bound publications) and microfiche (microfilm images on cards). The majority of the 1,500 microfiche kept by the library are also project reports.

Another feature of the research library and the SRS research information system is the collecting of abstracts on the R&D projects. Each abstract indicates the problem being researched, the method used in solving the problem, the major results obtained, and the usage potential for that project's findings.

Research briefs, made available through this system, also have been a welcomed addition to the holdings. Originally these were two-page research highlights in printed format but some are now in audiovisual form. They may be ordered from the National Audiovisual Center, Washington, D.C. 20409.

Many reference materials have come from the SRS research information system. Indexes, thesaurus, project listings, directories, and guides to information centers have added to the comprehensiveness of the collection.

In addition to the resources based on the information system, the library stores and disseminates 300 books, 10 journals, 2,500 articles and pamphlets, 50 newsletters, and the current year's radio tapes. Films owned by the Department of Vocational Rehabilitation are distributed through the Division of Information Services.

Staying up to date requires constant review of journals, bibliographies, abstracts, and various advertisements, as well as input from staff members who use the facility. Maintaining mailing-list status with all relevant State and national associations, research and training centers, regional rehabilitation research institutes, State and national governmental agencies, information clearinghouses, and selected book publishers is a must. Such status results in monthly newsletters, research reviews, research reports, and bibliographies.

Selective notification of information from two sources has been an asset to the process of staying current. Subscriptions to *Government Reports Topical Announcements* and *Weekly Government Abstracts* on selected topics keep the librarian advised of current governmental and government-sponsored publications. The National Technical Information Service publishes these periodicals. The Law Enforcement Assistance Administration, U.S. Department of Justice, has a national criminal justice reference service. Interested professionals submit subject preferences which make up a personal profile for selective notification of information in abstract form.

The services do not stop with the limits of the local collection. Oftentimes the librarian taps nearby libraries and information centers for materials or answers to questions.

In March 1973, a branch library was established in the Norfolk Regional Office. It offers similar services in a similar manner (though on a smaller scale) as the main library and uses guidelines prepared by the librarian in Richmond. While the branch library is responsible primarily to the Regional Director, its materials are coordinated with the main library. The Richmond library keeps records of materials available at both locations, as well as monthly statistical information on circulation at both points. Successful cooperation between them may lead to expansion to other regions in the near future.

In many ways the library can be considered the hub of an information network. The information-seeking professional brings his problem to the library. The librarian helps him identify the dimensions of his needs and assists him in matching his specific needs with the relevant resources. When these are not accessible locally, the librarian either makes appropriate referrals or secures the information for him by interlibrary loan or search requests to a system such as the Virginia Medical Information System. By staying alert to the trends on the domestic and national scenes, especially as related to rehabilitation, the librarian can anticipate informational needs and thus stay current in the changing world of rehabilitation.

Miss Edwards is a research librarian, Virginia Department of Vocational Rehabilitation.

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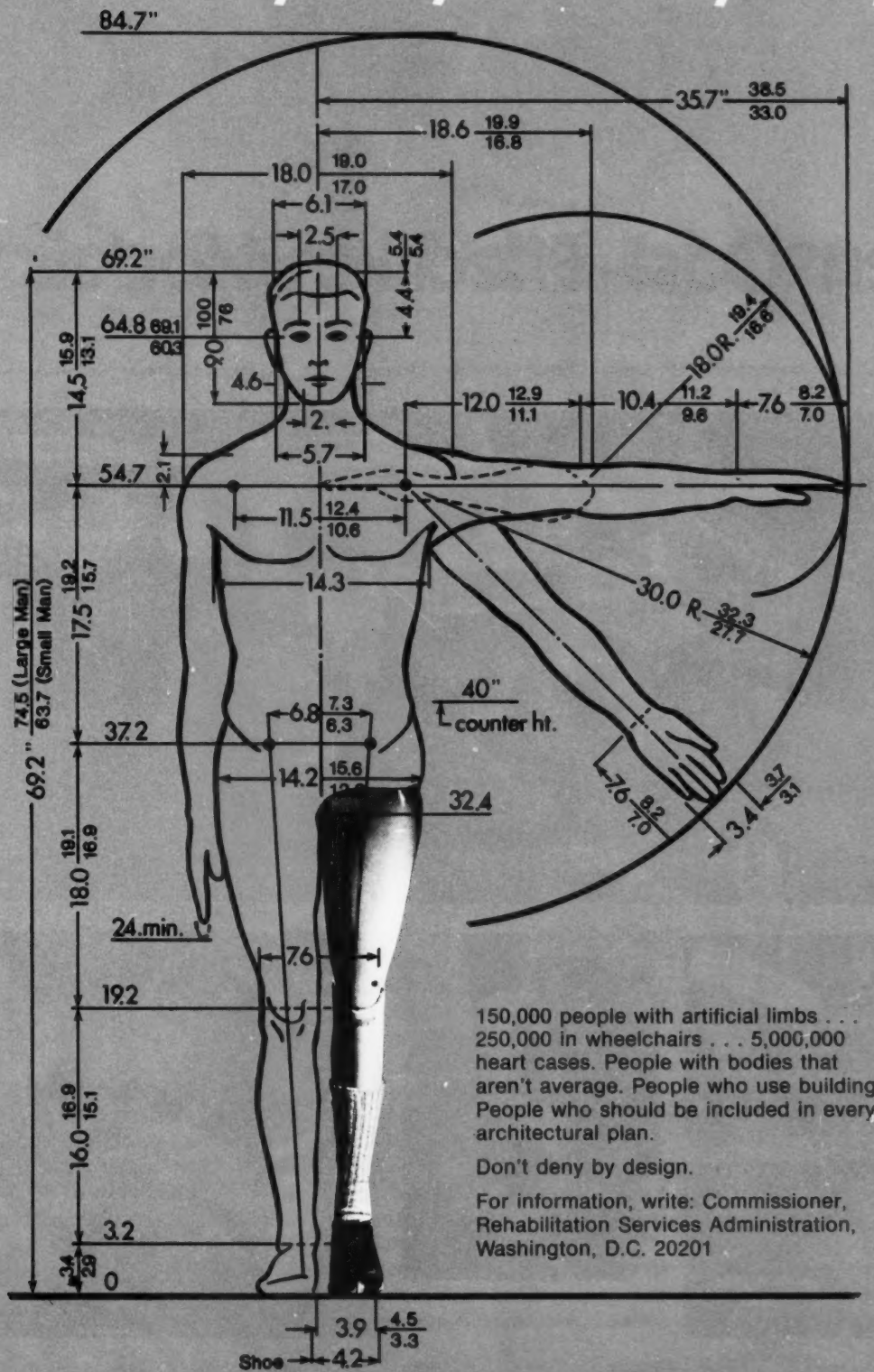

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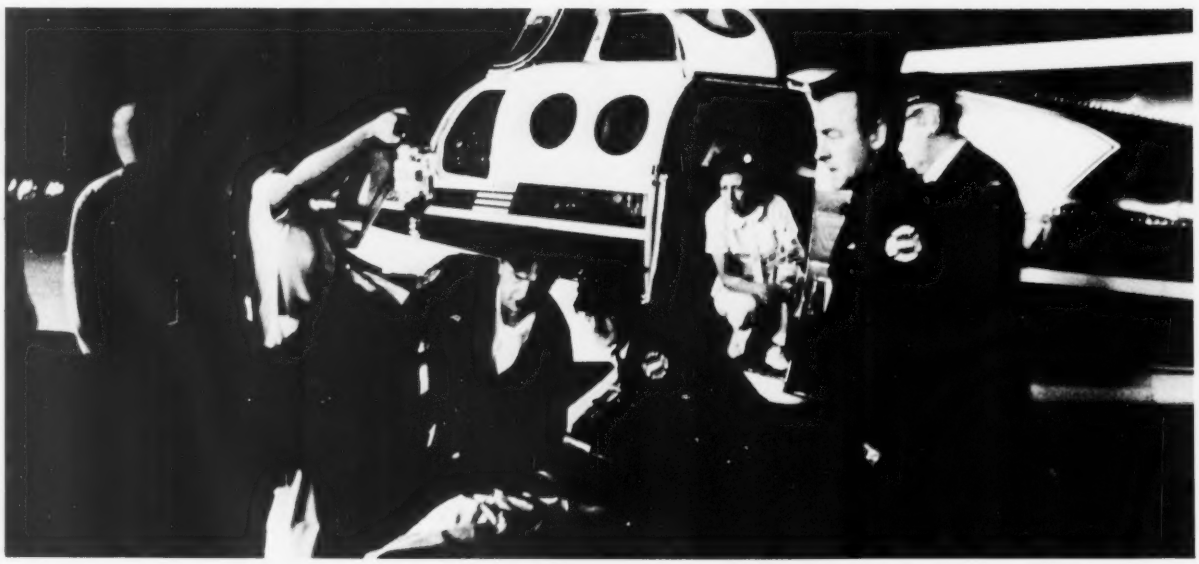
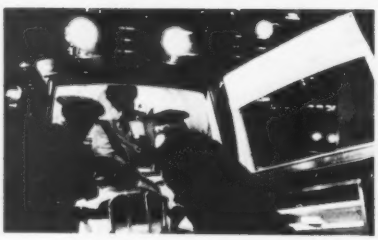




r Treating Spinal Cord Injuries

J. PAUL THOMAS

Rehabilitation has long recognized the significant economic and social impact made on society by patients with spinal cord lesions, especially when compared with other types of neurologic conditions. New spinal cord injuries (SCI) occur at an estimated 7,000 to 10,000 cases yearly. Annual mortality is estimated between 1,800 and 3,000 deaths, far below the 200,000 from stroke, but about equal to those of epilepsy, multiple sclerosis, and Parkinson's disease. Estimates of the total number of SCI cases in the U.S. are placed between 100,000 and 125,000. The annual cost of care is estimated at $2.4 billion; cost for all other neurologic conditions is much lower.

Several major reasons account for the apparent discrepancy between the relatively low number of cases and the high estimated cost of care.

Firstly, SCI occurs in a young population. In a survey of over 700 new patients at the Texas Institute for Rehabilitation and Research in Houston, the average age at onset was 25. Excluding industrial accidents, for which the average age was 40, the average is between 21 and 22 years. SRS research indicates 80 percent of SCI occurs in the 15 to 30 age range.

Secondly, patients with traumatic spinal cord lesions now live longer than previously. During WW I, the average life expectancy was 6 to 12 months postinjury. During WW II, the average was approximately 2 to 3 years postinjury. Presently, it is not significantly shortened in most patients who receive adequate care, such as that provided by SRS projects described later in this paper.

Thirdly, a spinal injury, particularly in the upper spine, is a severe catastrophic injury that affects most bodily organ systems, and it requires treatment and rehabilitation by a variety of specialists.

Also, over the last decade, several SCI programs have observed a change in the ratio of new paraplegics and quadriplegics (SCI categories) from 65 percent and 35 percent, respectively, to 50-50, and now many are experiencing 65 percent to 70 percent quadriplegics in their new patients.

Based upon an SRS-supported study conducted at Phoenix's Good Samaritan Hospital and on the expert opinion of insurance industry representatives, the lifetime costs of an average quadriplegic is $325,000 to $400,000. This figure is based upon an average age of 31 with an additional conservative life expectancy of 20 years or 50 percent of the normal additional life expectancy. (See table.) Because of lower costs for initial hospitalization, attendant care, and medical complications, the costs for a paraplegic are estimated to be $180,000 to $225,000.

Estimated Lifetime Costs For A Quadriplegic

Initial Hospitalization (240 days at $120 per day)	$ 28,800
Routine Maintenance ($200 per year for 20 years)	4,000
Hospitalization for Complications (60 days/year x $100 = $6,000 x 20 years)	120,000
Environmental Modifications	1,000
Lifetime Medical Costs	$153,800
Attendant Care ($6,000/year x 20 years)	120,000
Loss of Income ($6,000/year x 20 years)	120,000
Vocational Rehabilitation and Training	3,000
Total Costs	$396,800

SRS research projects have analyzed specific cost data for the various medical SCI complications. As examples, the closing and treatment of a decubitus ulcer (bed sore) averages $7,000; clearing a urinary infection, $4,000 to $6,000; kidney stones, $5,000, plus the possible loss of the kidney; and contracture deformities average $2,000 to correct.

Perhaps more important than the costs of disability is the loss of independence and the quality of living.

Rehabilitation workers around the world have long recognized these patients as a special challenge to their professional capabilities, patience, and frustration tolerance. More than any other disability, spinal cord injuries cause catastrophic physical and psychological problems that augur rehabilitation failure. All too often, they spend months in hospitals, followed by the rest of their lives in nursing homes.

Generally, they are not rapidly referred for rehabilitation, many facility staffs are not experienced or equipped to handle them, and continuing medical complications prevent effective rehabilitation planning. Consequently, only a small number achieve the level of self-sufficiency, family participation, and vocational success that they should. As an example, very few cases are rehabilitated each year by the State-Federal rehabilitation program.

The Role of SRS

In 1967 and 1968, several experts testified before Congress for a national effort to improve and expand rehabilitation services to the spinal cord injured. Subsequently Congress directed SRS to study methods and alternatives of delivering the wide range of services needed. Several conferences of nationally recognized specialists were held. SRS research findings were evaluated and gaps were identified in the present service delivery system.

Consequently, SRS proposed a conceptual model to Congress, to other health research agencies, and to the rehabilitation field. It has gained international attention and recognition. The model provides for rapid case finding and referral, early rehabilitation coordinated by a highly sophisticated team, a mechanism to use all the necessary community agencies and services to facilitate rehabilitation success, and a long term community followup program to assure that gains and adjustments are maintained.

In June 1970, the Good Samaritan Hospital in Phoenix was awarded a research grant that brought together the resources of the Spinal Cord Injury Service of Good Samaritan, the Barrow Neurological Institute of St. Joseph's Hospital, the Arizona State University, the Arizona Division of Rehabilitation, and the air evacuation program of the Highway Patrol.

Since then, SRS has supported six additional model regional systems on a demonstration basis. Besides measuring and analyzing the effectiveness and costs of the model system approach, these projects also evaluate regional or local variations and modifications in SCI service delivery.

In addition to project funding, significant gains have been achieved by SRS in coordinating the total national effort of SCI rehabilitation. As examples, SRS and the National Institute for Neurological Diseases and Stroke (NINDS) collaborate in research project review and monitoring, information exchange, and program consultation. The award of four of the seven SRS grants has been to institutions that receive NINDS planning grants for Acute SCI Treatment Research Centers. Also, SRS works closely with the Veterans Administration SCI centers, Regional Medical Programs, and the Emergency Medical Services for HEW and DOT. From the nongovernmental sector, the National Paraplegia Foundation and Paralyzed American Veterans have been consulted.

The model system has the following five objectives:

- To establish within a catchment area or region of natural patient flow, a multidisciplinary system of providing comprehensive rehabilitation services to meet needs from point of injury (emergency treatment and transportation) through acute care (rehabilitation, including vocational and educational preparation, community and job placement, and long-term followup);
- To demonstrate and evaluate the benefits to persons served in regional systems and to determine their cost effectiveness;
- To achieve new knowledge through research in reducing and treating SCI and its complications;
- To demonstrate and evaluate the development and application of improved methods and equipment essential to the care, management, and rehabilitation of the SCI; and
- To demonstrate methods of community outreach and education for the SCI in housing, transportation, recreation, employment, and other community activities.

Current Project Activities

The original Model Regional System at Good Samaritan Hospital is

in its 4th grant year while the other six have about 18 months experience. All seven of the model regional systems are making excellent progress in meeting project objectives described above.

Of major significance has been the establishment of standardized data base. This joint data gathering allows standardization of nomenclature and definitions; specification of effective measures, patient variables, and cost benefits; and the development of a single computer program for identical statistical treatment and analysis.

Also coordination of all system components assures that areas of service from emergency evacuation through acute medical treatment and rehabilitation care are thoroughly meshed for rapid and efficient rehabilitation. To achieve project objectives, including the collection and analysis of specified data, each component of the system must be fully operational and coordinated with all other components. The existence of the service delivery model is basic to all project activities.

Aside from the basic project evaluation and systems analysis of medical, physical restorative, and psychosocial and vocational services, other activities include research, teaching and public education, prevention, and community advocacy.

Good Samaritan Hospital is a leader in SCI public education and teaching. Each year, many hundreds of hospital administrators, medical school and university officials, community and health service planners, and rehabilitation personnel gain

first hand knowledge at the hospital.

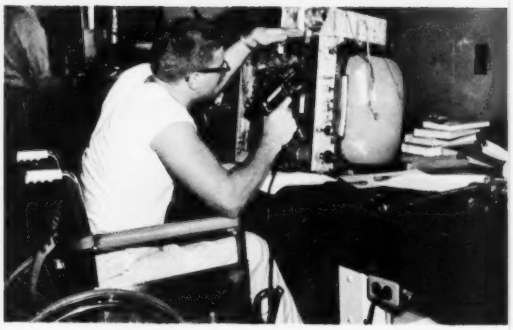
In October 1973, the International Conference on the Acute Management of Spinal Cord Injuries was hosted by the Good Samaritan staff and the Veterans Administration. Physicians from 14 countries observed the latest clinical techniques, many of which were developed through the combined research efforts of Good Samaritan and St. Joseph's Hospitals.

Project staff at the *University of Alabama* in Birmingham has developed innovative programs to meet local needs and conditions. A handbook, written by the nursing team, helps the patient learn self-care techniques. It describes and illustrates methods for performing procedures in the home, utilizing equipment available to the patient and his family in this environment.

The center has conducted 1-day seminars for public health nurses from every county in Alabama. At the conclusion of the fourth and final seminar, 126 public health nurses had attended.

A home-health care team provides innovative followup services, in addition to gathering information on the adjustment and complications of patients. It has successfully placed into employment more than twice the cases previously rehabilitated.

Staff at the *Texas Institute for Rehabilitation and Research* (TIRR) in Houston report an increasing number of high-level spinal cord injuries (cervical vertebra 1, 2, and 3) with involvement of breathing mechanisms. According to Dr. R. E. Carter, Director of the Spinal Cord Center, there is a 2 to 1 admittance ratio of traumatic quadriplegic patients to paraplegic patients.



Because of the many respiratory quadriplegics at TIRR, a special research project is evaluating the use of electrical stimulation for electrophrenic respiration. In a patient with a high spinal cord injury above the third cervical vertebra, the phrenic nerves to the diaphragm which control the majority of respiration may be spared. About 20 years ago a method of stimulating the phrenic nerve was devised for polio patients. This technique has not always been successful with SCI patients. More recently, implanted electrodes, which are attached to a subcutaneous receiver, have been utilized with a transmitter placed over the skin. This allows the diaphragm to be paced.

Several patients have now received implants. One, a complete lesion injury at C 1-2, is able to breathe by means of an electrophrenic respirator, thus obviating the use of cumbersome breathing equipment. This has improved her mobility, and she has finished her 1st year of college, functioning well in a wheelchair.

Also at TIRR, alternatives to community living are being evaluated.

In New York at the *Institute of Rehabilitation Medicine* neuroelectric diagnosis is being investigated. Once perfected, the method should aid physicians in determining functional neuromuscular potential.

At the Virginia Model Regional

System, which incorporates the *Woodrow Wilson Rehabilitation Center* and the *University of Virginia School of Medicine*, several research activities have been initiated. The IBM Corporation is cooperating in one project to train and place severely disabled persons in homebound employment as computer operators and programers. The project is developing improved services to the severely disabled.

First, training services are expanded to include the full range of occupations ranging from computer terminal operator to computer programer. Secondly, technical back-home assistance is provided the trained client to help assure his successful functioning as a homebound employee.

In another research area, the university hospital's Department of Orthopaedic Surgery is evaluating specially designed and implanted springs for spinal column fixation. This technique was introduced by Dr. Marian Weiss of Poland during an SRS-sponsored consultation. By implanting coil springs along both sides of the spinal column, fracture dislocations in the thoracic region appear to be reduced more quickly and effectively than by other surgical intervention. This enables the patient to enter therapy and gait training programs more quickly after injury, with fewer complications and less deconditioning.

In the psychological area, the *University of Washington* Model Regional System in Seattle continues to study behavior modification and operant conditioning techniques to control pain and behavior. To date, this behavioral approach promises to become an effective intervention to prevent dependency and withdrawal.

The *Northwestern University* Model System project staff in Chicago are conducting research similar to that at the University of Virginia. By combining the patient populations, a larger sample for clinical evaluation is possible. Its staff has also developed a special cervical spine fixation unit for application at the accident scene. It immobilizes neck fractures during extraction and transportation. The physicians have trained the ambulance attendants of the Illinois Emergency Medical Services Program in proper methods of evaluating, handling, and transporting spinal cord injury cases. More than 40 fixation units are being evaluated.

Preliminary Effectiveness Data

To date, very preliminary information has been collected by the several projects. Only the original model system in Phoenix has been collecting systems and cost data for 3½ years. Although the data is incomplete and should be considered tentative, there are identifiable trends in system effectiveness and cost benefits.

Data from the 1st year's experience of the six other projects appear to generally confirm the following:

- Length of initial hospitalization and rehabilitation is averaging 101 days, opposed to 180 to 240 days in a nonsystem.
- Costs for initial hospitalization and rehabilitation are averaging $11,000 compared to $18,000 to $28,000 for first hospitalization in a nonsystem.
- More than half of the system patients are being admitted to acute care hospitals within 4 hours after injury.
- More than half of new spinal cord injuries are of quadriplegic level. Many high level C1, C2, and C3 quadriplegics with total paralysis and respiratory dependence are living because of improved emergency care and transportation. This places new demands on service providers.
- Forty-two percent of injuries are incomplete lesions with potential for some neurological recovery. Improved medical and surgical techniques are increasing functional recovery, at a saving of $150,000 per case.
- The incidence is approximately 35 new cases each year per million population. Mortality rate is estimated at 10 percent within 1st 6 weeks postinjury.
- Proper followup after rehabilitation can reduce annual medical costs of $4,000 to $6,000 to less than $1,000.
- The VR rate and successful community adjustment can exceed 75 percent of all surviving SCI cases.

Collectively, these projects represent a most important research and demonstration effort by a federal agency in partnership with sophisticated private sector rehabilitation institutions. Their success can lead to the experience and know-how for developing a truly cost effective, beneficial service delivery program.

Mr. Thomas is the executive secretary and project officer, Medical Research Studies, Office of Research and Demonstrations, RSA.

Good ECF Staffs Make Good Patients

LOUIS MAIER

At a training program for nursing home administrators, I asked for volunteers in order to demonstrate a resocialization session for senile patients. Each volunteer was asked to role play a patient in his home who presented difficulties. To my chagrin each chose to represent a totally unreachable patient. As the sessions progressed, each participant made very clever efforts to avoid being reached. They were all sending the same message: "See, you can't do a thing with our difficult patients." The professional's first reaction to this kind of resistance may be a feeling of defeat. The resisting participants had proven their point! However, the underlying message was: "We have decided that the patient is unreachable. He is an enigma to us."

We all have the tendency to "tune out" the difficult or the painful. For example, cultural differences between staff and patient may cause problems in understanding and communications. Likewise, erratic behavior by a patient or a speech impediment may contribute to this misunderstanding.

We all speak about the generation gap and cultural and social differences. We assume them to be barriers to communication. Confused thinking leads us to believe the mute to be deaf, the aphasic to be without understanding, the psychotic to be stupid, and the senile to be bereft of feelings.

In addition to the problems of communication, the healthy person also has difficulty understanding the feeling of losing the use of parts of his body, of feeling tired, of lacking sight for reading, or of being blind.

He has difficulty assessing what the patient can do for himself or in what areas he may need help.

Again, the healthy person easily overlooks the shock an aged and sick person feels when he enters a nursing home. He cannot recognize the feelings in these people of having been dumped or doomed. But for the ill person, there is a loss of privacy; there is a forced association with other people who are severely ill; there is confusion or unhappiness.

If it is difficult for the trained administrator to understand patient behavior and to communicate with him, it can be assumed that other professional and paraprofessional members of the staff also have difficulty in being sensitive to the needs of the nursing home residents. No amount of professional training and status necessarily relates directly to being sensitive to the needs of aged and sick patients. Very few medical and nursing staffs are oriented to the problems of the nursing home resident. More likely than not, they come to work in these settings by chance rather than by choice. Very few have extensive experience with the chronically ill, the aged, or the senile.

Although professional staffs usually set the nursing home tone and standards, the closest patient contacts are made by nursing aides and orderlies. Additionally, housekeeping and maintenance staffs work in close proximity to patients. Together, these groups represent the largest number of employees having patient contact. They usually have the least education. They learn best by doing and from example—lectures and assigned readings are quite ineffective. Even high test scores are poor indicators of future appropriate functioning.

Since these groups generally have rapid personnel turnovers, special procedures should direct them to their mission in the nursing home. In developing understanding of their role and involvement in their jobs, powerful deterrents against their leaving the institution can be created.

We can expect professional staffs to learn from case presentations, their own readings, and attendance at special courses dealing with long term care. Professional staff members also attend institutes and meetings through institutional funding. But when the aim is for greater sensitivity, all staff members can benefit from inservice training.

To develop sensitivity we have used the following teaching methods: 1) Discussion and case presentation, 2) role playing, 3) psychodrama, and 4) demonstration sessions.

The major emphasis in *discussion and presentation* has been the involvement of staff. Since the institutions are small, the patient presented is known to most of the staff. Discussions are not necessarily handled in a classroom session. Some cases are discussed on the unit, with all staff participating. To assure that all staff members who are working with a patient are involved, a special case conference time may be set up in which the physician presents medical aspects and the nurse reports on problems of care and management. The aides and orderlies are asked for their reactions. The social worker presents the social background of the patient, family attitudes, and discharge plans.

All disciplines are involved in developing a revised patient care plan which not only includes aspects of medical needs, but also recommends action in meeting the patient's emotional, social, and activity needs.

Role playing has proven to be an excellent technique in sensitizing staff. Two procedures may be used. In the first, staff participants are asked to become patients by realistically playing out the problems encountered by patients. This is done through the use of auxilliary equipment. One staff member feeds another a bland diet while the second (the "patient") is alternately in a prone, slightly raised, and sitting position. Then the roles are reversed.

The possible diversity of this technique is limitless. For example, eyeglasses can be used to distort eyesight. This accomplished, the "patient" learns what happens when he walks with and without an escort. Wheelchairs, crutches, restraints, and even the hospital bed itself present teaching possibilities. A bandaged limb gives the new "patient" a sense of what it may be like to a real patient.

While these situations evoke merriment in the staff, the laughter is usually "nervous." It is most frequently derived from embarrassment, but the real message gets through. Suddenly and often with a new awakening, the "patient" gains a whole new perspective on wheelchairs, restraints, and dependency. To further

exemplify the real patient's plight, the trainees are encouraged to assist their fellow "patients" in varying degrees. The crisis of need is never so real as when a called-for bedpan does not arrive immediately!

In all these procedures, the staff is involved in bandaging, applying restraints, and general patient care.

Nursing procedures may be taught by using role playing techniques. A real body substituting for a mannequin is more realistic in teaching bedmaking. Likewise, the genuine item has more relevance than, for instance, teaching bathing techniques or patient transfers than they would have on film. In proceeding thusly, the staff member learns how it feels to be moved, to be handled, to be helpless. There certainly are limitations since the staff member who plays the patient role feels no pain. Also, many procedures cannot be performed on staff.

The learning experience applies equally well to the staff member who underestimates patient limitations as to those who equate "patient" with utter helplessness. The trainee learns what a patient can do in spite of his limitations. He may demand greater self-help from some patients.

In addition, the teaching process can show how two patients can work together to help each other. This has implications for developing patient buddy systems. It also has implications in the placement of certain patients as roommates.

A second form of role playing pertains to cultural and social situations.

Not long ago, I met an 80-year-old patient, a former stockbroker from a Southern State. He had been placed in the nursing home by his lawyer-guardian. He had lived by himself, but he had become confused at times. Finally, the decision was made to place him in a facility where people would look after him.

He had arrived the evening before I had met him, but that afternoon he was calling for his lawyer. He wanted to leave. In discussing the situation with him, I found out that his troubles stemmed from language and cultural misunderstanding of his black orderly. That morning, the orderly had said, "Mr. X, let's take a shave." And the orderly had given him a shave. Next, the orderly said, "Now Mr. X, let's take a shower." This was when Mr. X wanted to leave. He told me, "In all my 80 years I have never taken a shower with a colored man and I won't start now."

Cultural and generational problems can be ameliorated through role playing. Since a person is imbued from birth with his cultural trappings, and he acquires generational mores as he goes along, he may not be aware of their effect on others. Often the aged patient will take literally a cynical remark. Staff often does not know whether to laugh at or with the patient. But the process works both ways, with the staff member sometimes feeling insulted by the patient.

In role playing, staff members present problems they are having with patients. They ask, "What should I have said to this patient when she insulted me?" Initially, he plays himself while another staff person plays the patient. The roles are then reversed. The aim is to have the staff member get the feel of how his response comes across. Alert patients can participate in role playing, which then can be used as a problem-solving device. Not only does the staff member become more aware of his behavior, but the resident can understand the staff member's reaction.

In a demonstration of role playing, I asked an administrator to play a Medicaid patient who was entering her institution. She said she found this difficult because she did not believe in Medicaid. Her stated philosophy was: "People should provide for their old age, and children should take care of their parents." But she finally agreed, and through role playing she learned to identify the problems which many aged and sick are facing regardless of prior socioeconomic standing.

The techniques developed in *psychodrama* by Moreno may be used in addition to role playing. In this form, two additional characters are added to the cast. In addition to staff member and patient, their alter egos are performed by two additional staff members. The alter ego expresses the thinking of the patient and the staff member. Thus staff members become not only sensitive to what is said but also to what people are thinking. Fears, earlier experiences, and thought processes are laid open. It becomes clear why a patient's remark may be threatening to the staff member and vice versa.

This method is useful only after staff has had experience with simple role playing. It demands a certain

amount of openness and creativity by the staff. Once mastered, however, it is an excellent technique for increasing staff awareness.

Since staff members meet patients as patients, they naturally tend to think of them only in that relationship. Yet they must be made aware of the patient's background and past experience so that they may better relate to him. I have developed two techniques to help in this area of *demonstration.* I call them instant nursing home resident and resocialization program demonstration.

In the first, staff members pair off. One member interviews the other regarding his present activities and interest, life styles, etc. The pair then receives a transfer form from a hospital to a nursing home. The interviewee now is the patient, as described in the transfer form. The pair then develops a daily activity schedule, considering former life interests and present limitations. This exercise leads to understanding the patient as a total person. And it helps the staff to further identify with the patient.

In teaching resocialization techniques, I work with four or five patients with the assistance of two staff members. In turn, I ask each patient such questions as: "What is your name? Where are you from? Are you married? Do you have children? What kind of work did you do?" The aim of these sessions is to involve the patient by getting to know him and getting him to communicate with the other patients. The staff participates in this process. They can replicate the programs throughout the week. In this way they learn more about the patient: the fact that he can be reached, can be talked with, and, not infrequently, that he is a person of some accomplishment. Following these sessions, staff members are asked to meet with the patients regularly using the techniques.

The awareness methods described here should involve all facility personnel. For example, dietary department workers should know their patients and understand their backgrounds, habits, and tastes. Housekeeping personnel who are in close contact with patients need to understand patient fears and desires.

Since the turnover in these departments is high, special effort must be made to include all staff members in the training and to keep a checklist of such participation.

Of course, the techniques presented here are not exhaustive. Much insight can be gained through contact with the patient's doctor and family. Such records as social histories will also yield deeper and better understanding of the patient. When these methods are used conscientiously, nursing home staffs can gain a more sympathetic understanding of the patient as a whole person. They can understand his fears and help to allay them. They can recognize his needs and help to meet them. And, not least of all, they can gain a deep-seated satisfaction in having contributed in a worthwhile endeavor.

Dr. Maier is a special consultant to NIMH.

New Jersey Expands Innovations in Service Planning and Delivery

CAROL H. KURLAND

The Community Social Services Center (CSSC) of Hamilton Township New Jersey opened its doors in January 1971 to provide public welfare services to low income families and individuals in a suburban area. It grew out of an SRS-funded Section 1115 project, awarded in July 1970 to the N.J. Division of Public Welfare.

Over a period of 2½ years, this experiment was evaluated by Booz-Allen Public Administration Services of Washington, D.C., who studied the effectiveness of its social services delivery system and the system's exportability to the statewide public welfare programs.

Center goals included finding methods of maintaining and strengthening family life and helping the disadvantaged achieve self-support.

The motivation for such a program began with the 1967 Social Security Amendments which required the separation of eligibility determination from service delivery. In New Jersey, which still operates with county administered welfare departments, each county was attempting to carry out a true separation. Because of county staff involvement in procedural readjustments and continued adherence to traditional methods, it seemed unlikely that the counties could test this mandated structure adequately. For this reason the Community Social Services Center was proposed, accepted by HEW, and implemented.

CSSC staff were State employees, working in the municipality of Hamilton Township, with a county welfare board (Mercer). Agreements of cooperation among all levels of administration were effected before the project proposal was submitted for federal funding. The service area consisted essentially of a rural and suburban community of approximately 80,000 persons, living within 40 square miles. In accordance with federal guidelines, social services were to be offered and provided not only to the public assistance group, but to those low-income families considered "former" and "potential." Although the latter were ineligible for financial assistance, they were still in need of services unavailable from private voluntary agencies.

(For the most part, family service and child guidance agencies had waiting lists, had no home visitation programs, nor outreach services or special skills to accommodate the low income group. Eventually it was learned that 25 percent of families seen in intake in CSSC were in need of ongoing services and of these, 30 to 35 percent were nonpublic assistance families and individuals.)

Four main aspects were tested in the model:

Separation of Services and Payments

The CSSC was situated in a shopping mall in the heart of the township. Because the Income Maintenance Unit (IMU) of the County Welfare Board in early project days was geographically separated from the CSSC (the Welfare Board's Hamilton Township services unit), many problems related to the separation were en-

countered. These related to interstaff communication, use of records, forms, and client convenience.

While physically separated, the County Welfare Board seemed most threatened by the center's existence. Because of its large, well-paid staff (State salary scales were somewhat higher than county), reduced work loads, and innovative programing, the board viewed the project as a "country club." It was not until a special IMU to handle all township eligibility problems was located at the center that both agencies could gain a full appreciation of each other's problems and programs. Once accomplished, the marriage proved compatible.

Despite the presence of the IMU in the center, the separate employers, with their direct lines of accountability to State and county, and the mandated functional separation, promoted a spirit of separation.

Federal regulations (*Federal Register,* Vol. 38, No. 32. 2-16-73) on services dictates a functional but not necessarily a physical division. Some States could not facilitate physical separation, seeing it as a disadvantage, contrary to the CSSC experience.

The County Welfare Board referred all recipients to the center's intake section and, in return, CSSC performed all social studies and annual social service reviews. Making an intake worker available to every recipient to explain agency and community resources seemed to be a viable approach to service provision. Consumers could accept or reject continued services, but they were better prepared to make the decision.

The basic purposes of separation of services from income maintenance were to:

- Enable monitoring and evaluation of service quality and increase accountability of State agencies for services delivery (discussed more fully below);
- Aid in removing the welfare stigma from service delivery;
- Improve the quality, effectiveness, and efficiency of service and income maintenance functions;
- Permit a division of labor, so that social workers could function as "agents of change" while welfare technicians could provide financial assistance to maintain the status quo (see Thompson, Genevieve M. "Separating Social Service from Financial Assistance." *Public Welfare.* Summer 1971. Vol. XXIX, No. 3).

Client reactions were positive to the provision of social services by CSSC as separate from the County Welfare Board's IMU. These were documented in the February 1972 quarterly evaluation by Booz-Allen.

Agency effectiveness, highlighted in consumer interviews, seemed to be the result of several factors. They included the provision of information about community resources and service, the agency's advocacy role, the promptness of service delivery, the accessibility of personnel, and the quality of staff.

Workers also were invited to assess the advantages and disadvantages to service delivery. As advantages, they listed their ability to perform an advocacy role; to concentrate their time, effort, and energies on successful service delivery; to allow for an open and honest communication with consumers. They commented that clients seemed more receptive and motivated to reach service objectives since they perceived the program as voluntary and, therefore, not as a condition for eligibility.

Nevertheless, the workers felt that confusion could result from the separated system if procedures were not clearly defined to both consumer and agency staff. They felt that management should recognize this fact in planning for separation.

Service Integration

Service integration refers to the development of coordination, strong working relationships, and effective communication channels between agencies. Its purposes are to increase the range and accessibility of services available to clients, increase the efficiency and effectiveness of service delivery, and prevent unnecessary duplication of service resources. It is, then, a method of insuring that services available through a variety of community agencies can be mobilized toward the achievement of client goals.

In recognition of this concept, CSSC identified a host of agencies that could be used effectively to meet client needs and incorporated some under its roof or arranged for the agency's inhouse representation for a specific time period each week. Included were the Income Maintenance Unit of the County Welfare Board, Planned Parenthood, Well

Baby Clinic of the Township Health Department, the Bureau of Children's Services, the N.J. Rehabilitation Commission, and the Mercer County Probation Department. Inhouse on occasion were representatives from the Alcoholism Center and the Social Security Administration local office.

A unique fluidity of movement between agencies existed. At times office and home interviews were conducted together. CSSC staff meetings were attended by all inhouse agencies. Outreach programs were a concerted effort. A Booz-Allen evaluation revealed the following findings:

- Workers reported that personal contact and accessibility of other agency staffs had increased their own effectiveness and performance as well as that of the other staffs.
- Service integration provided a one-stop service delivery for clients and resulted in increased accessibility to a wider range of services.
- Service integration facilitated the development of closer working relationships and more effective operational linkages between CSSC and its inhouse agencies.

Evaluating Service Delivery

Throughout the period of CSSC operations, a management information system was utilized to measure service effectiveness in terms of impact on consumers. Its purpose was to increase agency accountability for services delivered and to generate an information base on which program, resources, and other management decisions can be made. In addition, it identified unmet client need, reported the occurrence and cause of prematurely terminated objectives, and tracked "reopened" cases. Thus, management was provided information necessary for program control, program development, and resource allocation.

The information system developed was called the Case Service Effectiveness System (CASE), which measured service effectiveness against two dimensions: 1) client movement toward objective achievement and 2) viability of client movement—measure of the extent to which the client's capability for self-reliance or independent problemsolving has increased as a result of his contact with the service agency.

There were two major system components. *Case Identifying Information* identified and recorded a profile of information on the client, including data on family income, family structure and size, employment status, educational achievement, and other relevant socioeconomic data. It also identified the means of client contact and referral source—information that feeds into the agency's outreach program and information and referral networks.

Case Service Information System (CSI) was the cornerstone of the effectiveness evaluation. It recorded each client objective, objective start date, services performed, and community resources utilized for each objective. The number of office and home visits were also recorded by the CSI subsystem.

Client movement to objective achievement was measured against a scale of 0 to 4, 0 indicating premature termination, while 4 indicated objective achievement. The intervening codes indicated various intermediary degrees of achievement.

Viability of client movement was measured against a scale of 1 to 4 with 1 indicating that the client would probably be dependent on the service agency for solution of a similar reoccurring problem and 4 indicating that he functioned independently and probably would not need the CSSC resources in the future. The codes in between represented varying levels of independent functioning.

CASE collected and reported service data quarterly. It was computerized to facilitate data processing.

Innovative Organizational Model

The center was divided into three main sections: *Case Control, Information and Referral* (name changed to *Community Relations and Resources* at a later date), and *Direct Services,* subdivided into *Professional* (intensive) and *Paraprofessional* (supportive) units.

The initial point of contact for a client was in case control where the social worker identified problems or barriers, formulated a diagnosis and service plan with the client in which goals and objectives were identified, recommended services, and determined the disposition of a case.

A new concept, "control," was introduced. In addition to performing their intake functions, the control social workers monitored service provision, oversaw the client progress to assure he would not get lost in the

traditional bureaucratic welfare process, and that required and needed services were indeed given through other units of the agency. The final responsibility for termination of services was carried out in this section. This monitoring responsibility was to be administered by weekly contacts between control social workers and service workers, in which case progress was reviewed in relation to individual and agency goals.

Although the concept of control was deemed an effective management tool after a year's implementation, the intake social worker was found to be ill equipped and most reluctant to perform the task. The difficulty arose because case control workers with identical expertise, experience, and job classification questioned the decisions made by their colleagues, the direct service workers. The service worker, along with the client, seemed in a much better position to evaluate the needs of the situation and involvement of the agency. In most instances it was the information they provided which determined whether termination or agency continuance would be undertaken.

This peer "supervision," ineffective as it was, also seemed to obviate a need for the traditional supervisor-worker relationship which coexisted. As a result, in order to really test the concept of "next friend" (a term used in the original proposal), the control function was maintained, but transferred to the case control supervisor, a person with an MSW degree, who had more expertise and greater authority in the project scheme. It was through this 3rd party review that the concept of time-limited goal-oriented services was finally successfully implemented.

The intake contact by case control section social workers or the social service aide had three dispositions:

- Short term or emergency service could be provided and the case terminated, usually with a 72-hour time limitation. The nature of this service could range from furnishing information about community resources to serving as an advocate in getting help from another agency.
- A social study or intake summary could be completed; client could express disinterest or lack of need of services and the case could be terminated.
- Client could request services that were only available from the Direct Services Section on an ongoing basis. The case then would be forwarded to the section with a clearly defined service plan developed with the client. Forwarded also would be the social worker's recommendations.

The flow of the case was from control (intake) worker to control supervisor to direct services supervisor for assignment to service social worker.

The control supervisor identified the time of the first control review, anticipating the approximate time period service provision would be needed to meet service objectives. Control contacts, that is, meetings between the case control supervisor and other section or unit supervisors, with input from workers or aides, were held on a weekly basis, with a percentage of ongoing service cases reviewed at each meeting.

Control reviews covered five areas of concern: 1) Initial goals and objectives, as stated by the case control worker; 2) any revisions in goals and objectives which may have occurred as the result of subsequent contact with client; 3) services given, actual client movement toward goals, and assessment of viability of client movement; 4) an evaluation of agency's role and the setting of a time period for future involvement or termination; and 5) suggestions toward continued service provision, if indicated —actual method of provision was the responsibility of direct services. At the end of each review, the control supervisor either set a new review date or termination was recommended.

Operationally, a card for each case receiving service was maintained by the control supervisor. A tickler system was instituted so that it was easy to administer time sequences. Most cases required approximately 5 to 10 minutes to review, assuming that the service supervisor had prepared himself and was fully cognizant of all aspects of the case. The case record file was used for reference. The control component, probably unique at this time in a public service delivery system, resulted in a higher turnover of clients with no apparent increase in service repeaters, in agency effort to decrease dependency and fulfill goals, in a speedy provision of services, and in the elimination of the "Banking" of cases—the practice of holding cases that have received services in an inactive service status and, thereby, considering the case as

"open" statistically. When such practices are used, reports cannot reflect the true service caseload.

Finally, the responsibility for termination remained with the control supervisor. There was no "warehousing" or "banking" of cases not being served. Goals and objectives were well defined, movements toward goals and client's viability of movement were continually assessed and reviewed. Contact with client was terminated either through a mutual decision on the part of the client and the agency or "prematurely" by the control supervisor when he felt that current progress and prospects for future progress were insufficient to justify the expenditure of more funds.

The *Information and Referral Section* (later called *Community Relations and Resources*) provided information required by clients and also served as the liaison with various community agencies that provided through referral such services as probation, medical, adult education, rehabilitation, and employment.

It was felt that this staff could handle all referrals. Practice demonstrated, however, the ineffectiveness of this system. All service workers soon knew about the community because of their outreach efforts. With intense staff and cooperating agency communication in the center came a general sharing of expertise and resources. Often referrals were made at the point of initial contact in case control (intake). Thus, there appeared no need for this specialized service.

Employment remained the one service continued in information and referral, mainly because of the contact that this section had developed with the State Employment Service. However, in review, this area of service also came under close scrutiny. Most persons seeking help from a social services center such as CSSC were hard core unemployables, with little skill, physical or emotional handicaps, illiteracy, the very young, and the old. The traditional employment service approach of a quick interview and placement often was inadequate.

In most instances, motivation was limited; employers were turned off by negative attitudes, absenteeism, obstacles placed in the way of effective employment by the worker, such as family problems, etc. Clients traveled from one employment to another, building up a record of erratic performances, unreasonable behavior, and layoffs. These persons were in need of motivational counseling, supportive help to the families to enable the wage earner to enter the job market unencumbered by problems of housing, transportation, medical needs, and financial concerns. This could only be provided in the Direct Service Section. Thus, the utilization of the separate Information and Referral Section was challenged and the section was eliminated from the project.

The need for a person with community knowledge remained. Job responsibilities would include communication with the community as an ongoing process to interpret ever-changing agency program, development and administration of outreach and public relations programs, and channeling of unmet needs among consumers and the community as conveyed by line staff, so that the program could be designed to meet service gaps.

The largest section of the agency was Direct Services which was subdivided into two units, the professional and the paraprofessional for intensive and supportive services.

In the section also was a home economist-nutritionist who served as a consultant to staff and also worked directly with clients, in matters relating to home management, consumer education, nutrition and diets, budgeting, housing, etc. Her role was expanded to include nutritional counseling with the well baby and family planning clinics.

The professional unit was manned by social workers with BA degrees and supervised by an MSW. It was responsible for services such as family and individual counseling and family therapy, family life education, child welfare and guidance, adult protection and self-care, and all forms of casework.

The use of BA personnel in this professional capacity was most productive. Extensive ongoing, inservice training was given to the staff.

Untrained workers were able to develop special skills to enter treatment areas, traditionally closed to non-MSW personnel. A key to the success of such activity was the close training and working relationship maintained by all supervisors with their immediate staff. Weekly conferences, unit and general staff meetings, and direct involvement in all

situations have been standard operating procedure.

The paraprofessional unit was staffed by social service aides who had a 5th grade education or higher. Their career ladder program provided for part-time educational leave, and exposed them to such services as long and short term transportation, housing, and housing rehabilitation, consumer education, visiting of shutins, home management, and shopping, and other supportive services. They worked directly with families or in cooperation with the social workers.

An extensive network of group programs was developed as the result of the needs expressed by clients. Group programs helped in serving more people more cheaply and some persons were more at ease in the group setting. Goals and objectives, time limits, and methodology of programs were well defined before implementation of group activities.

Various outreach efforts plus client requests at intake led to the development of two tutorial programs, one coordinated with Neighborhood Youth Corps and the other community based, utilizing the facilities of a local church and volunteer high school students. In addition, group activities included recreational programs for residents of sheltered boarding homes and for adolescent boys, a preteen charm course, a "better meals for your dollar" course for low income mothers, and discussion groups for adolescent girls and for single mothers.

Many skills and talents were discovered in staff and in the community in the development and operation of these group activities. A needs analysis should include an examination of staff in terms of their potential interests or abilities. Staff was used differentially in the provision of services. Supervisors and social workers performed together in family therapy teams; social workers and aides conducted group discussion; aides handled an entire group program from the planning stage through to implementation; supervisors relieved social workers and/or aides in direct intake or service to clients.

In effect families became known to the entire agency and were handled as an agency case when specific personnel were unavailable. Most clients seemed to flourish under this system. They seemed pleased that many staff members were aware of their situation and were eager to help.

Efforts To Export the Model

In an attempt to carry out the Section 1115 mandate that requires the building of project activities into a continuing State system, CSSC undertook in its 3rd year of funding a concerted effort to disseminate methods and concepts which were tested and proven during the demonstration period.

Through its efforts at dissemination, CSSC hoped to become a catalyst for change in the greater public welfare system. A social service systems team, consisting of the project director, assistant director, case control and direct service supervisors, and a newly hired systems analyst was created for visitations to the county welfare boards. The team viewed as its responsibilities: the assessment of the status of each county welfare board with respect to separation, the development of a proposed organizational structure based on size and qualifications of staff and client population, and the proffering of technical assistance to implement and make operational separation and other concepts developed at CSSC.

The outreach efforts of the systems team to the counties, the advent of the February 1973 federal regulations on family and adult services, and the impending depletion of Section 1115 demonstration funds laid the groundwork for a new mission for CSSC staff. On March 19, 1973, the center was officially transferred to the new service division, the Division of Youth and Family Services, under whose auspices it would complete its service delivery program, embark into new horizons, do research and planning, and provide technical assistance to the counties. Initially, the task would be assessment of separation, hopefully followed by technical assistance to the County Welfare Boards directed toward improved service delivery and management programs.

Mrs. Kurland presently is a Social Work Supervisor I, Bureau of Research, Planning, and Program Development, New Jersey Division of Youth and Family Services. She wishes to thank Rita M. Ryder, M.S.W., Consultant, Booz-Allen Public Administration Services, for information provided in support of various sections of this paper.

Publications and Films

The Editors of the SOCIAL AND REHABILITATION RECORD regularly receive notification of the release of new publications and films of interest to readers.

Each issue of the RECORD will carry a selected list of these publications and films with brief discriptions of their contents.

Please address all inquiries and requests to the addresses given in this listing.

Residential Treatment of Emotionally Disturbed Children. George H. Weber, Ph.D., and Bernard J. Haberlein, editors. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 327 pages. $14.95.

A broad selection of 20 articles written by specialists working with emotionally disturbed children in residential settings has been collected in this volume. The writings cover four general topic areas: concepts and strategies, some treatment issues, treatment approaches, and training and manpower.

Behavior Modification in Residential Treatment for Children. Frank J. Pizzat, Ph.D. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 98 pages. $7.95.

Subtitled "Model of a Program," the book establishes just that—a nontechnical guide for the partial or complete implementation of a behavior modification treatment program for emotionally disturbed children. Presented for and by child care workers in residential treatment centers, this program design uses particular experiences with the center children to discuss treatment goals, principles, and rationale.

Adaptations and Techniques For the Disabled Homemaker. Karen Hodgeman, O.T.R., Eleanor Warpeha, O.T.R. Sister Kenny Institute Publications Department, 1800 Chicago Ave., Minneapolis, Minn. 55404. 29 pages. $1.75.

Indispensible to many disabled homemakers are specific equipment modifications and techniques which enable the person to manage the home—meal preparation, dishwashing, housecleaning—with greater ease. Designed as an aid for occupational therapists, nurses, and patients and their families, this illustrated booklet describes the construction, purchasing, and use of these simple and inexpensive household devices.

A Guide to College/Career Programs for Deaf Students. E. Ross Stuckless, Ph.D., and Gilbert L. Delgado, Ph.D., editors. Produced by: National Technical Institute for the Deaf and Gallaudet College. Available from: Howard Quigley, Executive Manager—Conference of Executives of American Schools for the Deaf, 5034 Wisconsin Ave., N.W., Washington, D.C. 20016.

A listing of 27 postsecondary programs for deaf students in America is presented in this guide for student, counselor, parent, and teacher. The booklet reports and describes each program according to its location, enrollment, cost, emphasis (liberal arts, technical or vocational), basic services, and preparatory activities: It further advises the student in certain broad areas of college/career direction. Also included are descriptions of majors chosen by deaf students in each institution.

Observation and Client Evaluation In Workshops. A Guide and a Manual. The Department of Rehabilitation and Manpower Services, School of Education, University of Wisconsin-Stout, Menomonie, Wisconsin 54751. 33 pages.

The following is quoted from the manual's introduction:

"Evaluation of the work potential of rehabilitation clients, that is, characterization of their assets and their work deficiencies and planning for further service to them, is frequently based upon observation of the behavior of clients in workshops and other sheltered work programs. The ability of the floor supervisors, or foremen, to observe events in the workshop and to make inferences from the observations are critical elements in planning further steps in clients' rehabilitation programs. Therefore, training in observation and in the use of observations is essential for floor supervisors. They need to know what to observe, how to observe it, and what to make of the observations. This guide and the accompanying manual are designed to help in training workshop personnel in how to observe."

Children and Their Parents in Brief Therapy. Harvey H. Barten, M.D., and Sybil S. Barten, Ph.D., editors. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 323 pages. $9.95.

Short-term strategies in child psychotherapy are outlined in this collection of professional writings. The book treats therapy for both child and parent including: crisis intervention, time-limited therapy, preventive intervention with infants and preschool children, group and family approaches, behavior modification, classroom techniques, and pharmacotherapy.

From Poor Law to Welfare State. Walter I. Trattner. The Pree Press, A division of MacMillan Publishing Co., Inc., 866 Third Ave., New York, N.Y. 10022. 276 pages. $9.

This history of social welfare in America synthesizes the main social welfare policies and practices from the Colonial period to the present.

Set against the background of developments in American history, especially social and intellectual trends, this book assimilates numerous earlier studies to provide a broad overview of American social welfare. The book also traces the development of a variety of social welfare activities such as alms, charity, poor relief, philanthropy, and social reform.

The book is organized both chronologically and topically. Among the topical chapters are "Child Welfare," "The Public Health Movement," "The Mental Health Movement," and "The Quest for Professionalism."

Living with Multiple Sclerosis. Marcella Zaleski Davis, R.N., D.N.S. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 71 pages. $5.75.

Subtitled A Social Psychological Analysis, this text is tailored to the needs of health workers. It examines patients with progressively worsening multiple sclerosis and how they accommodate to a continual decline in their health and mode of living.

The implications of this material for the work of health personnel are based on three key factors:

1. The unique clinical features of multiple sclerosis can easily be misinterpreted by those caring for MS patients.

2. The patient population consists mainly of young and early middle aged persons who are at a stage in life when role pressures and obligations are most pressing.

3. These patients and others with serious chronic illness share problems of a social-psychological nature which derive from a set of similar circumstances.

Rehabilitation of the Urban Disadvantaged. John G. Cull and Richard E. Hardy,

editors. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 62703. 215 pages. $9.75.

This book combines theoretical information and practical case study descriptions of approaches and attempts to solve problems relating to disadvantagement, poverty, and drugs.

The book presents information on such subjects as models of service, rehabilitation techniques, and materials in story-like form.

Part I of the book describes rehabilitation models which could be useful with the urban disadvantaged and continues with some psychosocial considerations in working with poverty stricken clients.

Part II is a collection of case studies representative of the urban problems of deprivation, delinquency, and drug abuse.

Psychosocial Rehabilitation of the Blind. Alvin Roberts. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 62703. 83 pages. $8.95.

Newly blinded persons must cope with numerous psychological and social problems related to visual impairment. Counselors, teachers, social workers and other rehabilitation workers play a major role in helping the blind adjust.

This book, written from the standpoint of a practitioner in the rehabilitation of the blind, presents a variety of techniques these workers can use to help the blind.

Included in this text are techniques to enable the visually impaired to cope with the depression often associated with blindness; the psychological reorganization necessary to carry on life functions without sight; and using the visualization process for facilitating learning and adjusting to a new environment.

Paroled But Not Free. Rosemary J. Erickson, Wayman J. Crow, Ph.D., Louis A. Zurcher, Ph.D., and Archie V. Connett. Behaviorial Publications, 72 Fifth Ave., New York, N.Y. 10011. 129 pages, $9.95.

Sixty parolees, a representative sample of those on parole in San Diego County, were systematically interviewed in depth by a research-trained team of six exfelons. *Paroled But Not Free* resulted from those interviews.

In the book these exoffenders talk about what they need to make it outside. The reader experiences with them their pressing physical, social, and psychological needs, and shares with them the assaults on their self-esteem.

The parolee's reflections and supporting data are interpreted meaningfully in terms of social theory, and yield a detailed set of recommended changes for the post-release system, if it is to operate humanely and effectively.

This book will enlighten general readers, human services workers, students of law, psychology or political science, and criminal justice system professionals from judges to parole officers.

Outreach: Extending Community Services in Urban Areas. Joseph J. Bannon. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 62703. 219 pages. $12.75.

Most outreach programs and approaches are tied to recreation. The outreach concept presented here goes beyond that. The basic purpose of this outreach is to help disadvantaged youth use their free time constructively and at the same time introduce these youth to essential community resources in education, health, employment, recreation, and related social services.

This book provides methods and techniques to accomplish these objectives.

The main subjects discussed include the evolution of the outreach program in the U.S., outreach in urban areas, the outreach worker's role, program planning, referral process, the role of education, administrative problems, and evaluation of personnel.

Films

The Behavior Game. Color. 8 min. International Film Bureau, 332 S. Michigan Ave., Chicago, Ill. 60640. Sale $150. Rental $12.50.

Using a bank and its employee training program as the background, this lighthearted film focuses on the positive and negative effects of individual attitudes on overall behavior and personal interaction. Despite its specific concern, the film may be used as a discussion device in training psychiatric nurses and aides.

We Tiptoed Around Whispering. 16 mm. Color. Sound. Total Communications Laboratory, Western Maryland College, Westminster, Md. 21157. Rental $15.

Written by Joanne Greenberg, award winning novelist (*I Never Promised You a Rose Garden, In This Sign,* and other books), this film is a combined dramatization and documentary on what parents of deaf children experience from the birth of their child until the deafness is diagnosed. It is a powerful film which tends to arouse intense feelings in parents. It is for use with the families of deaf children (particularly young ones) and with professionals who desire more understanding of the psychodynamics parents experience in the discovery of their child's deafness. It is available with or without subtitles.

Still Life. Color. 16 min. Film Library, Ohio State University, Department of Photography and Cinema, 156 West 19th Ave., Columbus, Ohio. 43210. Sale, $150. Rental, $8.

Still Life portrays the present existence of Jack—a 24-year-old quadriplegic. The film unfolds a sequence of events following his crippling accident—his hospital stay, the rehabilitation process, and his eventual placement in a nursing home.

The portrayal raises many questions regarding Jack's attitude and his relationship with society; it also considers certain means available to partially relieve the dependency, limitations, and stillness of his life.

Total Communication. 16 mm. Color. 15 min. Rental $8. *Swan Lake: Conversations with Deaf Teenagers.* 16 mm. Color. 15 min. Rental $6. *Intolerable.* 16 mm. Black and white. 10 min. Rental $4. Dr. Earl Griswold, Director, Total Communications Laboratory, Western Maryland College, Westminster, Md. 21157.

The following three films consider different aspects of communication for those impaired by deafness or hearing loss. Each film is produced for use by professionals and by parents of deaf children.

As its title indicates, the first film considers the rationale and effectiveness of total communication. It involves the viewer in a preschool class of deaf children and in interviews with parents of young deaf children. It is available with or without captions.

The second draws its audience into direct contact with deaf teenagers—their views and opinions on life. Filmed at the Junior National Association of the Deaf Camp, Penguilly, Minnesota, the film is presented in sign language with an accompanying spoken narrative interpretation.

Actors from the National Theater of the Deaf appear in the third film in the educational and comic entertaining guises of basic vocabulary instructors for deaf children.

Career Opportunities

SPEECH AND HEARING THERAPIST I. BS degree with course in speech correction, speech pathology, speech therapy, communicative disorders, child development (with a minimum of 6 semester hrs. of special education), or deaf education/education of hearing impaired. $8,957-11,128. Write: State Personnel Dept., 404-A State Administrative Building, Montgomery, Ala. 36104

SPEECH AND HEARING THERAPIST II. Master's degree with course work in speech correction, speech pathology, speech therapy. Experience in the respective skill areas. $10,387—12,766. Write: State Personnel Dept., 404-A State Administrative Building, Montgomery, Ala. 36104

HEALTH SERVICES ADMINISTRATOR I. Bachelor's degree plus 3 yrs experience in an agency providing or supervising the provision of medical or health services to individuals. Relevant experience above the minimum may be substituted for the required college training on a basis of 2 yrs. experience for 1 yr. of college. $10,387—12,766. Write: State Personnel Dept., 404-A State Administrative Building, Montgomery, Ala. 36104

HEALTH SERVICES ADMINISTRATOR II. BS degree with course work in public administration, hospital administration, public health administration, or one of the medical sciences, plus 5 yrs experience. Relevant experience above the minimum may be substituted for the required college training on a basis of 2 yrs. experience for 1 yr. of college. $11,856-15,158. Write: State Personnel Dept., 404-A State Administrative Bldg., Montgomery, Ala. 36104

MEDICAL SOCIAL WORKER II. Master's degree plus 4 yrs. progressively responsible experience in the field of social work including responsible experience in an approved program involving public health and medical social work. $12,246—15,834. Write: State Personnel Dept., 404-A State Administrative Bldg., Montgomery, Ala. 36104

DRUG ABUSE PROGRAM SPECIALIST. Master's degree with 5 yrs. experience in related field. Equivalent experience may be substituted for the educational requirements on a year-for-year basis. $226.40—275.10/per wk. Write: Maine State Dept. of Personnel, Augusta, Maine 04330

DIRECTOR. Office of Alcohol and Drug Abuse. Master's degree in one area of the human services discipline preferred, and 7 yrs. of experience. $237.70—289.00/wk. Write: Maine State Dept. of Personnel, Augusta, Maine 04330

MEDICAL FACILITIES PLANNER I. BS degree including or supplemented by courses in hospital, business or public administration, or any equivalent combination of training and experience, provided that no substitution of experience be made for the required 2 yrs. of college. $8,606—10,751. Write: State Personnel Dept., 404-A State Administrative Bldg., Montgomery, Ala. 36104

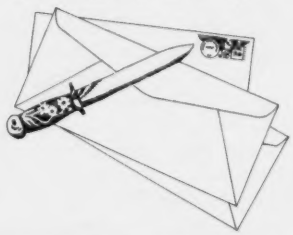
PATIENT PLACEMENT WORKER II. H.S. graduate plus 3 yrs. responsible experience in working with people having behavior problems in an institutional setting. $6,591—8,606. Write: State Personnel Dept., 404-A State Administrative Bldg., Montgomery, Ala. 36104

Mail your agency's classified listings to Editor, SOCIAL AND REHABILITATION RECORD, DHEW-SRS, Washington, D.C. 20201. Applicants should apply directly to the hiring agency, NOT this magazine. No "situation wanted" or non-governmental listings accepted. There is no charge or fee of any kind for this service.

CHILD WELFARE SUPERVISOR. Bachelor's degree supplemented by successful completion of at least 1 yr. of graduate study in a school of social work and 3 yrs. experience in professional social work, including 1 yr. of experience in the field of child welfare. $11,856—15,158. Write: State Personnel Dept., 404-A State Administrative Bldg., Montgomery, Ala. 36104

CASE WORK SUPERVISOR. Bachelor's degree plus one semester of graduate study in a school of social work accredited by the Council on Social Work Education, plus 2½ yrs. of social work experience in a public or private social agency. (An additional semester of graduate study may be substituted for 1 yr. of the required experience.) $10,751—13,312. Write: State Personnel Dept., 404-A State Administrative Bldg., Montgomery, Ala. 36104

ASSISTANT ACCOUNTANT. Associate degree in accounting, bookkeeping, or business studies and 1 year of bookkeeping experience; or graduation from HS or GED certificate, including coursework in bookkeeping, and 3 years of experience; or an equivalent combination of training and experience. $7,353—9,869. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.



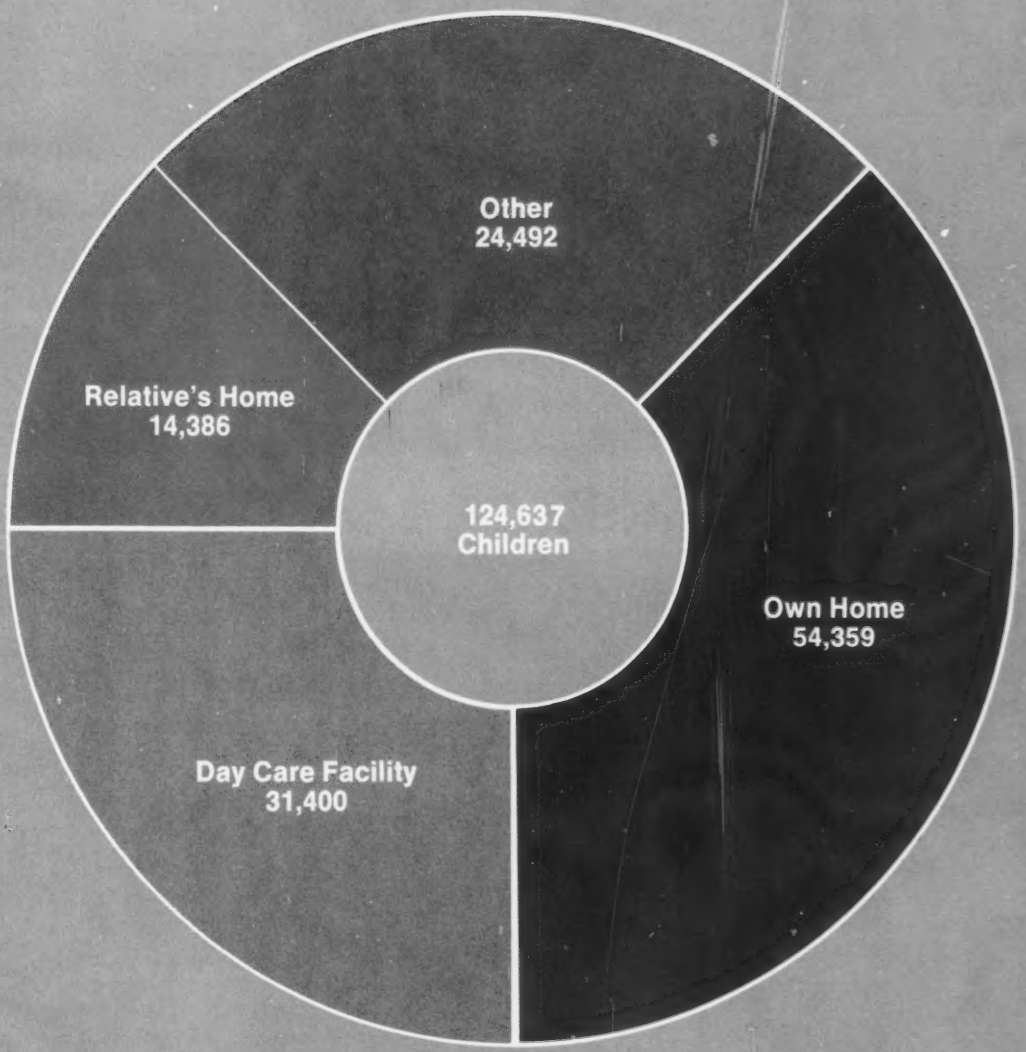
ADMINISTRATIVE ASSISTANT I. Associate degree in a field related to the position and 2 years of experience in administrative work, or an equivalent combination of training and experience. $6,992—9,404. Write: State Personnel Office 1228 N. Scott Street, Wilmington, Del. 19806.

ADMINISTRATIVE ASSISTANT II. Associate degree in a field related to the position and 3 years of experience in administrative work or work in the subject field; or an equivalent combination of training and experience. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

NEIGHBORHOOD WORKER III. Bachelors degree on a social or behavioral science or closely related field plus 2 years of experience in community work or social work; or successful completion of 60 credit hrs of college level coursework; preferably in the humanities, nursing, education, or behavioral sciences; and 4 years of experience. $8,543—12,096. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

EMPLOYMENT INTERVIEWER TRAINEE. Two years of progressively responsible experience as a public service worker, training NCO in the armed forces, armed forces personnel specialists, veterans organizations volunteer, community organizer or related field. $6,656—8,940. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

Children Receiving Child Care Under WIN During Fiscal Year 1973



As of June 30, 1973, there were 59,562 mothers or other caretakers participating in the WIN Program whose participation depended upon adequate child care arrangements (total would be higher since no data were reported for New York and incomplete data for Massachusetts). A total of 124,637 of their children received child care. The type of child care arrangements and the numbers of children receiving each type are depicted below. The category "other" represents such accommodations as the caretaker being in training or at work only during the child's school hours or the child looking after himself. Nationally, only 1,758 mothers or other caretakers could not participate in WIN programs solely because adequate child care arrangements were not available. (Data on nonparticipation were not reported for Arizona, Maryland, New York, Rhode Island, and Wisconsin.)

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